**Article - Health - General**

[Previous][Next]

§19–705.1.

(a) The Secretary shall adopt regulations that set out reasonable standards of quality of care that a health maintenance organization shall provide to its members.

(b) (1) The standards of quality of care shall include:

(i) A requirement that a health maintenance organization shall provide for regular hours during which a member may receive services, including providing for services to a member in a timely manner that takes into account the immediacy of need for services;

(ii) A requirement that a health maintenance organization shall have a system for providing a member with 24–hour access to a physician in cases where there is an immediate need for medical services, and for promoting timely access to and continuity of health care services for members, including:

1. Providing 24–hour access by telephone to a person who is able to appropriately respond to calls from members and providers concerning after–hours care; and

2. Providing a 24–hour toll free telephone access system for use in hospital emergency departments in accordance with § 19–705.7 of this subtitle;

(iii) A requirement that any nonparticipating provider shall submit to the health maintenance organization the appropriate documentation of the medical complaint of the member and the services rendered;

(iv) A requirement that a health maintenance organization shall have a physician available at all times to provide diagnostic and treatment services;

(v) A requirement that a health maintenance organization shall assure that:

1. Each member who is seen for a medical complaint is evaluated under the direction of a physician; and

2. Each member who receives diagnostic evaluation or treatment is under the medical management of a health maintenance organization physician who provides continuing medical management;

(vi) A requirement that each member shall have an opportunity to select a primary physician or a certified nurse practitioner from among those available to the health maintenance organization; and

(vii) A requirement that a health maintenance organization print, in any directory of participating providers or hospitals, in a conspicuous manner, the address, telephone number, and facsimile number of the State agency that members, enrollees, and insureds may call to discuss quality of care issues, life and health insurance complaints, and assistance in resolving billing and payment disputes with the health plan or health care provider, as follows:

1. For quality of care issues and life and health care insurance complaints, the Maryland Insurance Administration; and

2. For assistance in resolving a billing or payment dispute with the health plan or a health care provider, the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General.

(2) This subsection may not be construed to require that a health maintenance organization include certified nurse practitioners on the health maintenance organization's provider panel as primary care providers.

(c) (1) The health maintenance organization shall make available and encourage appropriate history and baseline examinations for each member within a reasonable time of enrollment set by it.

(2) Medical problems that are a potential hazard to the person's health shall be identified and a course of action to alleviate these problems outlined.

(3) Progress notes indicating success or failure of the course of action shall be recorded.

(4) The health maintenance organization shall:

(i) Offer or arrange for preventive services that include health education and counseling, early disease detection, immunization, and hearing loss screening of newborns provided by a hospital before discharge;

(ii) Develop or arrange for periodic health education on subjects which impact on the health status of a member population; and

(iii) Notify every member in writing of the availability of these and other preventive services.

(5) The health maintenance organization shall offer services to prevent a disease if:

(i) The disease produces death or disability and exists in the member population;

(ii) The etiology of the disease is known or the disease can be detected at an early stage; and

(iii) Any elimination of factors leading to the disease or immunization has been proven to prevent its occurrence, or early disease detection followed by behavior modification, environmental modification, or medical intervention has been proven to prevent death or disability.

(d) (1) To implement these standards of quality of care, a health maintenance organization shall have a written plan that is updated and reviewed at least every 3 years.

(2) The plan shall include the following information:

(i) Statistics on age, sex, and other general demographic data used to determine the health care needs of its population;

(ii) Identification of the major health problems in the member population;

(iii) Identification of any special groups of members that have unique health problems, such as the poor, the elderly, the mentally ill, and educationally disadvantaged; and

(iv) A description of community health resources and how they will be used.

(3) The health maintenance organization shall state its priorities and objectives in writing, describing how the priorities and objectives relating to the health problems and needs of the member population will be provided for.

(4) (i) The health maintenance organization shall provide at the time membership is solicited a general description of the benefits and services available to its members, including benefit limitations and exclusions, location of facilities or providers, and procedures to obtain medical services.

(ii) The health maintenance organization shall place the following statement, in bold print, on every enrollment card or application: "If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card".

(5) The plan shall contain evidence that:

(i) The programs and services offered are based on the health problems of and the community health services available to its member population;

(ii) There is an active program for preventing illness, disability, and hospitalization among its members; and

(iii) The services designed to prevent the major health problems identified among child and adult members and to improve their general health are provided by the health maintenance organization.

(e) (1) The health maintenance organization shall have an internal peer review system that will evaluate the utilizational services and the quality of health care provided to its members.

(2) The review system shall:

(i) Provide for review by appropriate health professionals of the process followed in the provision of health services;

(ii) Use systematic data collection of performances and patient results;

(iii) Provide interpretation of this data to the practitioners;

(iv) Review and update continuing education programs for health professionals providing services to its members;

(v) Identify needed change and proposed modifications to implement the change; and

(vi) Maintain written records of the internal peer review process.

(f) (1) Except as provided in paragraph (5) of this subsection, the Department shall conduct an annual external review of the quality of the health services of the health maintenance organization in a manner that the Department considers to be appropriate.

(2) The external review shall be conducted by:

(i) A panel of physicians and other health professionals that consists of persons who:

1. Have been approved by the Department;

2. Have substantial experience in the delivery of health care in a health maintenance organization setting, but who are not members of the health maintenance organization staff or performing professional services for the health maintenance organization; and

3. Reside outside the area serviced by the health maintenance organization; or

(ii) The Department.

(3) The final decision on the type of external review that is to be employed rests solely with the Secretary.

(4) The external review shall consist of a review and evaluation of:

(i) An internal peer review system and reports;

(ii) The program plan of the health maintenance organization to determine if it is adequate and being followed;

(iii) The professional standards and practices of the health maintenance organization in every area of services provided;

(iv) The grievances relating specifically to the delivery of medical care, including their final disposition;

(v) The physical facilities and equipment; and

(vi) A statistically representative sample of member records.

(5) A health maintenance organization accredited by an accreditation organization approved by the Secretary in accordance with § 19–2302 of this title shall be exempt from the external review.

[Previous][Next]